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DISCUSSION

FRANK E. WIEBE, M. D. (610 Salinas National Bank Building, Salinas).—Doctor Woolsey has, in his usual clear and direct way, presented to us the little-used method of abdominal examination. He has discussed the anatomy and physiology involved, and has pointed out the peritoneal reflex producing inhibition of peristalsis, this reflex being initiated by any irritation, which may be chemical, mechanical, or inflammatory.

Since it has been my privilege to review this paper previously, we have taken advantage of abdominal auscultation, both for diagnosis and for following our patients postoperatively. Our most unusual impressions have been in cases of acute appendicitis in which, as the author has stated, peristalsis is inhibited in the right lower quadrant, due to an inflammatory peritoneal reflex.

A case in which we felt the clinical and laboratory findings outweighed the findings of abdominal auscultation, and which was diagnosed as acute appendicitis, proved the value of this sign. A five-year-old child, ill about ten hours with abdominal pain localizing in the right lower quadrant with definite right lower quadrant tenderness and muscle protection and rebound tenderness. The white blood count of 20,000 with 82 per cent polymorphonuclears, but with peristalsis active over the entire abdomen including the right lower quadrant, was diagnosed as acute appendicitis. On operation, we found an appendix only slightly inflamed, but in the region of the terminal ileum were a number of large red glands.

Postoperatively, we have been impressed with the absence of distress in our patients since we have been permitting only minimal amounts of fluid by mouth until peristalsis had begun, food being withheld until peristalsis has become active.

I want to thank Doctor Woolsey for presenting this method, and feel that anyone who has not utilized it will find it a valuable addition to his method of examination.

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JOHN C. RUDDOCK, M. D. (1930 Wilshire Boulevard, Los Angeles).—The art of the practice of medicine which, in the absence of mechanical aids, was highly developed in our forebears, has been sadly neglected. Much dependence and finality is placed upon the findings of the roentgenologist, the hematologist, the chemist, and the bacteriologist to make the diagnosis. The five senses of man have been relegated to a minor position. Doctor Woolsey has called our attention again, and pointed out the value in diagnosis and the determination of course of treatment on the simple procedure of auscultation of the abdomen. No expensive equipment is necessary. No time is involved in the interpretation or decision. Every doctor has a stethoscope and is trained in its use. Interpretation of the intra-abdominal pathology is dependent on the physiological response to the reflex stimulated by the lesion, *i. e.*, peristalsis of the intestine. The art of the practice of medicine by applying one special sense—hearing.

Auscultation of the abdomen becomes of value in differential diagnosis in acute coronary thrombosis with abdominal splinting, or early lobar pneumonia and diaphragmatic pleurisy with reflex aperistalsis. Mesenteric thrombosis usually presents problems calling for all the skill and ancillary methods at the disposal of the clinician. Small amounts of ascites often give the patient a feeling of distention, but auscultation will reveal normal peristaltic sounds.

Many abdominal conditions when suspected are more clearly defined and localized if the simple procedure of auscultation is done. No abdominal examination is complete unless the stethoscope is used as a part of such examination.

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H. BRODIE STEPHENS, M. D. (384 Post Street, San Francisco).—Doctor Woolsey, in his customary manner, has presented to us a valuable contribution. He has called to our attention the many aids provided by the intelligent use of the stethoscope; he has particularly stressed the use of this instrument in helping the surgeon arrive at a correct diagnosis of various intra-abdominal diseases, as well as the successful management of the patient following operation.

While hearing Doctor Woolsey's presentation, the oft-time repeated words of the late John B. Deaver came back to me. When speaking of the silent abdomen, which follows the intraperitoneal rupture of an acute suppurative process within the appendix, Doctor Deaver would relate how the surgeon should frequently listen to the abdomen through the stethoscope. In his masterful and dramatic manner he would exclaim, "And now the tinkle of peristaltic waves becomes audible, which means the peritonitis is subsiding, and this indeed is music to the surgeon's ears!"

Doctor Woolsey has justly stressed the great value which lies in this simple method of physical examination. All of us, no doubt, tend to neglect the use of our eyes and ears when we have so many modern laboratory aids at hand. This neglect will certainly do the patient no good and may do him much harm.

It had not occurred to me before hearing Doctor Woolsey's paper how accurately one actually is able to follow his patient's postoperative course by the daily use of the stethoscope. Certainly, we have here an honest indication of what the gut is really doing. Doctor Woolsey is probably very correct in telling us we could dispense with much of our postoperative treatment if we would only use the stethoscope more frequently and intelligently.

A paper such as we have just heard seems to me to be a good one to keep close at hand, one to be read every six months or so. I feel certain that after each reading we shall be better doctors and less dependent on the laboratory.

In closing, I should like to congratulate the author for his excellent paper and to congratulate his patients, too. I believe them to be lucky people!

CALIFORNIA STATE HOSPITALS*

THE PROBLEM OF OVERCROWDING

By AARON J. ROSANOFF, M.D.
Sacramento

THIS meeting has been called mainly for the purpose of laying before you a plan of attack on the problem of overcrowding in State hospitals; for even a partial and hasty survey of the institutions in our Department has revealed this problem as the largest and most urgent one among those that present themselves at the present time. I need not cite the statistics, which are but too well known to you all. The great fact is that our overcrowding is so great as to be physically and mentally unhygienic, esthetically revolting, and altogether intolerable.

PROBLEM OF OVERCROWDING

This problem is neither new nor peculiar to the State of California. On the contrary, it has existed now for fully a century, in more or less marked degree, in practically every state in the Union. The obvious lesson to be learned, not only from our own experience, but also, and even more impressively, from that of older and more populous states, is that the building of new hospitals, or the enlargement of existing ones, or both, no matter on how large a scale, seems to afford but partial and temporary relief at best. Every state in the Union has had under way for many years an

* From the office of the Director of Institutions, State of California.
Read at a special meeting of medical superintendents and social workers, held at the Stockton State Hospital on January 10, 1939.

almost continuous program of hospital construction; and none has as yet gotten caught up with its overcrowding.

Accordingly, the question arises, Is it possible to devise a new and more effective policy for dealing with this problem? The plan which I wish to lay before you today assumes that this question may be answered in the affirmative, and represents an attempt to outline such a policy.

AVAILABLE RESOURCES

To begin with, we have now available something over $4,300,000 for major construction in our California institutions; and in the Governor's budget for the next biennium $4,000,000 additional is requested, and will probably be appropriated by the Legislature. Out of this total something over $4,500,000 is to be used for buildings to house patients. In this way our institutional capacity is to be increased by about 3,000 beds, at an average cost of about $1,500 per bed. I believe that this money can be made to go farther in regard to increasing our bed capacity, namely, to gain 4,000, instead of 3,000 beds, without in the least compromising the principle of Class "A" construction. The changes in plans that will be necessary in order to accomplish this will, of course, be fully discussed both with the superintendents of the respective institutions and with the State Architect.

TWO ACUTE NEUROPSYCHIATRIC UNITS PROPOSED

The second feature of my plan consists in the establishment of a 200-bed acute neuropsychiatric unit in connection with the University of California Medical School and Hospital in San Francisco; also, later, a similar one in Los Angeles. The Governor has consented to include in his construction budget for the next biennium $500,000, over and above the proposed appropriations already mentioned, for this purpose; and the University of California has offered to grant to the Department of Institutions a 99-year lease on a part of its land, which is admirably suited for such a unit.

FUNCTIONS OF AN ACUTE NEUROPSYCHIATRIC UNIT

A detailed discussion of the many functions which might be performed to good purpose by an acute neuropsychiatric unit located in a metropolitan area would be irrelevant in this connection. Suffice it to say here that, with the aid of its outpatient department, such a unit would greatly facilitate the recognition of mental disorders in their incipiency, and the application of appropriate treatment at a time when it would often be effective. I have in mind especially the employment of insulin-shock therapy, or metrazol therapy, or combinations of both, in schizophrenic and manic-depressive cases; malarial inoculation or other forms of fever therapy in cases of asymptomatic neurosyphilis, and the like.

This, if carried out on an adequate scale, should have the effect of materially reducing the admission rates of the most important psychotic groups. The State will then no longer maintain its institutions as mere passive receptacles for end-products of psychotic disease committed to them for custodial care as a desperate measure of last resort.

EXTRAMURAL CARE OF MENTAL PATIENTS

The final feature of my plan calls for a large-scale extension of extramural care of mental patients. At the present time about 2,800—which is 11 per cent—of our State hospital patients are out on parole. These consist, for the most part, of patients who have recovered, or have improved sufficiently to be able to return to their homes and to their work. Experience has shown amply that in many chronic cases, too—cases in which recovery would be quite out of the question—the patients can be helped toward an adjustment on parole in self-sustaining employment. It may be estimated conservatively that in this way the percentage of cases on parole can be raised from 11 to 20, or, in actual numbers, from about 2,800 to about 5,000.

INSTITUTIONS FOR THE FEEBLE-MINDED

What has been said concerning the hospitals for psychotic patients applies, to at least an equal extent, to the institutions for the feeble-minded as well. Thus, the outstanding fact in the existing situation is that the daily average of patients on parole can be increased from a total of about 3,500 to one of about 6,000.

SOCIAL SERVICE PERSONNEL

There is, however, but one way of doing this satisfactorily, namely, by greatly increasing our social service personnel. We would require for this purpose, I believe, not only highly qualified and technically trained senior social workers, to have charge of this activity, and junior social workers to assist them, but also large numbers of field workers to be placed under their direction. The field workers for the extramural work would correspond in rank, perhaps, to the attendants whom we employ for our intramural work.

We have now, altogether, sixteen social workers in our service. I am happy to be able to report to you that I have obtained the Governor's consent to include an item of $160,000 in our budget for the next biennium for the employment of thirty-six field workers in the social service departments of our institutions. It is estimated that this should result in a net saving of $940,000 in maintenance cost of patients during the biennium.

But the benefits of such an activity would be not only of a financial character. Generally, in properly organized and supervised extramural care, the patients are happier, the people with whom they live and work are pleased, and the institutions gain something more than relief of their overcrowding.

AUTHOR'S EXPERIENCE WITH PLAN

In an experience of this kind, had a number of years ago in a large State hospital in New York, I personally selected, by a fine-combing of all the wards of the hospital, the best working patients in an intensive drive for extending extramural care. There was much grumbling on the part of some

supervisors, attendants, cooks, dining-room employees, shop foremen, farmers, and others, who depended so much on the labor of these patients. Nevertheless, the plan was carried out; and pretty soon a situation arose wherein the employees were confronted with the alternative of either themselves undertaking the work previously done by patients, or breaking in other patients to do it—patients who had previously been idle and perhaps even untidy and destructive to boot.

In the face of this tragic alternative, all our employees, including the most untutored, soon became practical experts in occupational therapy and quickly rehabilitated large numbers of previously idle patients, converting them into excellent workers. That they did it by dint of bribery with tobacco, candy, extra helpings of food, special privileges, money, etc., and even by stooping to gentle diplomacy, is perhaps a sad commentary on the sordidness of human nature, as it manifested itself, in this instance, in both the employees and the patients. As for me, I had not the slightest compunctions; I felt that the end justified the means; and I have never offered an apology to anyone when it turned out, eventually, that a second crop of patients suitable for parole had been found among the newly trained workers.

FIELD WORKERS AND FAMILY CARE

An increase of our social service personnel, particularly by the addition of a large rank-and-file group to which I have referred as field workers, will, I trust, lead to another type of development of extramural care of mental patients, namely, the so-called family care. This consists in boarding out from one to five or six patients for care in private homes by an arrangement whereby the State pays a rate approximately corresponding to the per capita cost of maintenance in the institutions. The patients selected for such care are from amongst those who are too disabled physically, mentally, or both, to earn their board and room. On many farmsteads the cash income from such a source is greatly appreciated.

NEW YORK'S EXPERIENCE

A full discussion of the important and complicated subject of family care of mental patients could hardly be undertaken here. I would recommend for your careful perusal a very practical book on this subject recently published by Horatio M. Pollock, the statistician of the New York State Department of Mental Hygiene.

Over a thousand patients now receive such care in the State of New York, although this system has but recently been started there. It has been in operation for many decades in Massachusetts and in Scotland; and in the famous village of Gheel, Belgium, it constitutes the main industry of the community.

REIMBURSING PATIENTS

A point of some importance, in more respects than one, that should be considered in connection with the general subject of extramural care, is that of the possibility of arranging for the parole of certain reimbursing patients with a view to transferring them from the State hospitals to licensed private institutions. At the present time, for example, the total bed capacity of the private institutions is 3,120; the census of patients in them is 2,213; leaving 907 available vacant beds. The total number of reimbursing patients now in the State hospitals is 3,258. Of them, nearly 600 are paying more than $20 per month, which is the standard reimbursing rate, over 200 paying $40, which is the maximum that the State is permitted to charge under the law. No doubt, some could pay more.

In many of these cases, although probably not in all, an advantage would be gained all around, *i. e.,* for the patients, the State hospitals, the private institutions, and others concerned, if such a transfer were effected.

IN CONCLUSION

This concludes, in general outline, my statement of the proposed policy for dealing with our problem of overcrowding in the institutions of the Department. I should like to have you note especially that none of the features of my plan is new, or experimental, or conjectural. All of them have been thoroughly tried out in various places in this country and throughout the world over periods of years or even decades. What is new is the proposition to organize their operation in the State of California in a fully comprehensive manner.

For this purpose, each of us gathered here today, and each of those who are working under us, should act not so much as an independent unit, or one representing merely a local interest, but rather as a smoothly and effectively functioning element of a larger, more complex, and more important entity—a closely integrated Department of Institutions.

It goes without saying that such a plan as I am proposing cannot be put in operation all at once. I am sure it will require years for its full development. But it will not take care of itself. It will require harmonious coöperation, unity of purpose, and continuous effort on the part of each one of us. You will understand, therefore, my reason for taking it up with you at the very beginning of my service in office.

In so far as there may be differences of opinion among us concerning the fundamental features of the proposed plan, this is the time to have a free and full discussion of them; for at this meeting I should like very much, if possible, that we reach a decision on them by at least a majority of the executive officers of our institutions. When such a decision has been reached and recorded, I feel that any controversy which may have existed concerning the issues involved should henceforth be stilled. Every individual and every institution should then closely and loyally adhere to the policy thus adopted. In the future, any modification of policy, if found necessary, should be permissible only by a decision of a majority of the executive officers of our institutions, arrived at in a manner similar to that which we are pursuing today.

Department of Institutions.